

# Benefits At a Glance

Choice Plus

## Medical Plan

Primary Care Physician Required? No

	In-Network	Out-of-Network
<b>Deductible</b>		
Individual		
Family		
<b>Coinsurance</b>		
<b>Out-of-Pocket Maximum</b>		
Individual		
Family		
<b>Office Visits – Primary Care</b>		
<b>Office Visits – Specialist</b>		
<b>Preventive Services</b>		
<b>Lab Testing and X-ray</b>		
<b>Major Diagnostic and Imaging Services</b>		
<b>Emergency Room</b>		
<b>Urgent Care</b>		
<b>Convenience Care Clinic</b>		
<b>OP Mental Health/Substance Abuse</b>		
<b>Inpatient Hospital</b>		
<b>Outpatient Surgery</b>		
<b>Outpatient Freestanding Facility</b>		
<b>Pediatric Dental</b>		
<b>Pediatric Vision</b>		

## Pharmacy Plan

	In-Network/ Non-Network
<b>Retail</b>	
<b>Deductible</b>	
<b>Tier 1</b>	
<b>Tier 2</b>	
<b>Tier 3</b>	
<b>Tier 4</b>	
<b>Mail Order</b>	
<b>Tier 1</b>	
<b>Tier 2</b>	
<b>Tier 3</b>	
<b>Tier 4</b>	

Only certain prescription drug products are available through mail order. See your plan documents for details.

\*In-Network: Children's Eye Exams - \$35 Copay deductible does not apply.\*

\*Out-of-Network: Children's Eye Exams - 50% after Deductible

\*Children's Glasses not covered\*



This information is a brief, general description of your coverage; it is not a contract and does not replace your Certificate of Coverage/Summary Plan Description. For a complete list of your coverage, including exclusions and limitations relating to your coverage, please read your Certificate of Coverage/Summary Plan Description. If descriptions, percentages, and dollar amounts conflict with official benefit coverage documents, the official benefits coverage documents prevail.